ACCESS

Newsletter of the Nebraska Office of Rural Health, Nebraska Department of Health & Human Services, Division of Public Health *and the* Nebraska Rural Health Association for all rural health stakeholders

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A New Way of Thinking When There's No Doctor

by David Howe

What if the doctor isn't in? And won't be in—ever?

Such is the case in many regions around the globe, and certainly in Nebraska, where 80% of the state's 530 towns have populations under 1,000, where one of every three counties is a Frontier County (fewer than 6 people/square mile), and where roughly two of every three counties are a Family Practice Shortage Area.

Who's going to pick up the baton? Especially with aging populations and the companion rise in their healthcare needs? And when fewer family, friends, and neighbors are around for support in the midst of a trend to earlier hospital dismissals?

That was the stage set by Dennis Berens, President of the National Rural Health Association and Director of the Office of Rural Health in the Nebraska Department of Health and Human Services, and Dean Cole, Administrator of EMS programs in Nebraska, at a "Community Health Paramedic Summit" in June, at Grand Island.

The answer to those questions may lie in the title of that summit: Community Health Paramedic.

It's a concept that has been gaining attention and adoption around the globe over the past 5 years--in the rural and remote regions of such places as Nova Scotia in Canada, a region of Scotland, and in Queensland, Australia--Gary Wingrove told the Summit.

Pilot versions of the Community Paramedic program are already underway in the U.S., right next door to Nebraska--in Minnesota and Colorado, said Wingrove, Chairman of the International Roundtable on Community Paramedicine.

The Summit, attended by Nebraska EMS personnel, healthcare providers, and educators, was held in part to get a sense of the interest in moving ahead with the Community Paramedic concept in Nebraska.

Two summit speakers, one of them an emergency room physician, reported their experiences with the Minnesota and Colorado pilot programs. Their observations a bit later in this article.

Nebraska is looking over this process "to see how much interest there is in it before moving ahead in our state," said Cole who moderated the Summit.

Wingrove characterized the Community Paramedic program as "filling an unmet need with untapped resources." He pointed to the website www.communityparamedic.org, which includes the following description of the program. "It's a simple concept: Connect underutilized resources to underserved populations. In this case, we're expanding the roles of EMS workers to provide health services where access to physicians, clinics and/or hospitals is difficult or may not exist."

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The website refers to Community Paramedicine as a "new way of thinking" to address unmet healthcare needs in "communities that already include disproportionate numbers of elderly citizens, immigrants, impoverished families, and those in poor health." The EMS role could be expanded from emergency response to include continuing care.

It may even fit in some urban areas where healthcare needs aren't being met.

The idea is to follow-up with patients—monitoring such things as A1c levels in diabetics and blood pressure in cardiovascular patients, and insuring compliance with dietary requirements and medication regimens. That's a role Community Paramedics could play to reduce emergency room visits and hospital readmissions.

In the Nova Scotia program, this approach helped reduce ambulance trips to the emergency room by 40% and clinic visits by 28%, according to Wingrove.

Throughout the conference, speakers emphasized that the Community Paramedic program is not directed at broadening the scope of practice of EMS personnel. Rather, it's intended to expand the role of these personnel: "Using the existing scope of practice in a different way," Wingrove explained.

Only the emphasis on how the skill sets of EMS personnel are applied under the oversight of a licensed healthcare provider would change. A licensed physician would provide the oversight.

The aforementioned website explains: "The Community Paramedic Program closes the gap by expanding the role of EMS personnel."

An internationally standardized curriculum for training EMS personnel to fulfill this role is being offered free-of-charge to accredited colleges and universities for training those personnel at the appropriate level to serve communities more broadly in the areas of: Primary care, public health, disease management, prevention and wellness, mental health, and dental health.

The curriculum is available through the Community Healthcare and Emergency Cooperative (CHEC), in which Berens has been a leader since it was formed in this decade, to develop the community paramedic concept globally.

That standardized curriculum, which can be requested from the Community Paramedic website, www.communityparamedic.org, has already been made available to more than 20 colleges and universities, according to Wingrove. Creighton University, the University of Nebraska at Kearney, and the University of Nebraska Medical Center are among them.

Wingrove said he doesn't know how many of those institutions are using the curriculum, which is offered free-of-charge to any college or university that wants it, with the stipulation that the curriculum not be added to or sold.

Such a curriculum might eventually lead to several academic levels—a certificate, associate's degree, bachelor's degree or even a master's degree, Wingrove said.

Summit speaker Dr. Mike Wilcox, an emergency room physician who is working with the Minnesota pilot program, said Community Paramedics in that pilot program are his "eyes and ears." He cited several points to consider when entertaining implementation of a Community Paramedic program:

- Establish a need for this service.
- Before moving ahead with a program, hold discussions with healthcare personnel in the community to identify how the program can complement their work.
- Identify those who will promote the program.
- Emphasize that EMS personnel are not changing their scope of practice—they are utilizing their skills in an expanded role.
- Note that this might be an opportunity for EMS personnel to develop a career path

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EMS *cont'd from p. 2*

not previously available to them—or as a role they could fill when they no longer wish to or can handle the rigors of emergency calls in the middle of the night.

• Solve the payment-for-services problem.

Don Sheldrew, who works with the Minnesota pilot program and teaches a Community Paramedic course at the Hennepin Technical College in Minnesota, emphasized the importance of partnerships with organizations and integration of EMS with the community's healthcare system. Recognize that this will be a change in approach for EMS personnel who are used to dealing with patients on an emergency basis. They will need to adjust to looking at patients in terms of long-term needs, rather than the needs of the moment.

One place where the curriculum for this program could use improvement, Sheldrew suggested, is more emphasis on behavioral healthcare.

As the old saying goes, "The devil is in the details."

One of those details is terminology, Wingrove noted. Definitions and training of emergency response personnel such as paramedics and EMTs, along with the regulations applying to them, vary among states and countries. The path to a Community Paramedic program and what Community Paramedics can or can't do under such program are issues that need to be resolved. That holds true, whether a state takes a regulatory or legislative path to a Community Paramedic program.

Each path has its pros and cons, Diane Hansmeyer told the Summit. Hansmeyer, an administrator in Licensing and Regulatory Affairs in the Nebraska DHHS, said that no matter which route a state takes, it's important to have discussions beforehand with healthcare providers, educators, the governor and other elected officials, and administrative personnel involved with the process. It's also important to identify those who will champion the concept.

In rural areas where volunteer EMS is the rule, the question arises of how can a Community Paramedic program be sustained fiscally?

"We need to work on that," said Dr. Wilcox who provides licensed medical oversight of Community Paramedics in the Minnesota pilot program. So far, he said, the program is grant-funded, not self-sustaining. He suggested that each state will have to address that in its approach to a Community Paramedic program.

It's important "to show third-party payers that we do good work." he added. Show payers, for example, that patients aren't having to be readmitted to the hospital every 30 days, saving the payers money.

Personnel who might be tapped for this role might not be only emergency response personnel. They might be, for example, healthcare personnel at the local nursing home—or even law enforcement personnel trained especially for the role, noted one speaker during a question-and-answer session at the end of the summit. Or, a community might choose someone it would sponsor financially as a Community Paramedic.

Throughout the summit, speakers emphasized that the right approach to the Community Paramedic program won't necessarily be the same from one community to the next. Resources and needs will vary among communities.

Assess the gaps between what's needed for healthcare and the resources available for meeting those needs, said Berens, who had illustrated his point with a quote from Henry David Thoreau: "The question is not what you look at, but what you see." ☐

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If you have any questions, please e-mail Ann.Larimer@nebraska.gov.

2010 Nebraska Rural Health Conference
September 16-17, 2010
Kearney Holiday Inn
Kearney, Nebraska

Sessions planned include:

- Skill Training for Challenging Times
- Health Care Reform and its Impact for America and Rural Nebraska
- Health Information Technology: The Latest Information
- Workforce Challenges and Opportunities
- High-Tech Extension Center Support for Rural Providers
- Behavioral Health Issues and Actions
- Rural Health award presentations
- Coding/Billing Workshop for Rural Health Clinics

...and many other topics of interest!

For more information, contact Melissa Beaudette at mbeaudette@mwhc-inc.com

Rural health clinic "bits and pieces"

By Janet Lytton

Currently there is a requirement that all providers have updated provider information under Part B. This can be completed through the online CMS system using PECOS (Medicare), by your providers, not your facility (RHC). If providers do not update the information, any referral item, i.e. labs, x-rays, DME, etc. will be denied. Providers need to send in a Part B claim at least once a year or their provider number will be cancelled. CMS knows this may be a problem especially for providers that do not bill to Part B. CMS is to clarify this situation soon.

The online system used to obtain the Clinic PS & R is still a problem for many clinics. Clinics should not wait until the end of the year to get access to this system as the MACs/FIs will not be sending the reports out for the next cost reporting period. Keep all passwords and access I.D.s current throughout the year.

When speaking at the California RHC annual meeting last month, a CMS representative gave an update on the proposed regulations. There could be an increase to the capped rate up to $92. This could be acted upon by the end of the summer. No one is sure if this will actually happen.

This year, the NARHC Fall Institute will be held in Reno, Nevada, from October 20-22, 2010 at the Atlantis Resort Spa. RHCs are encouraged to attend. You can get all the information at www.narhc.org

If anyone has any questions, please e-mail me at RHDconsultJL@hotmail.com. ☐

SAVE THE DATE!

2010 Nebraska Rural Health Conference

September 16-17, 2010 - Kearney, NE
Info: www.RuralHealthWeb.org

Announcing the release of the Meaningful Use Final Rule

By Wide River Technology Extension Center (TEC)

Health information technology has the potential to improve health care quality, increase the efficiency of the care delivery system, reduce health disparities, and further engage patients and families in their health care. Realizing the full benefits of an electronic health record requires use in a meaningful way. The American Recovery and Reinvestment Act of 2009 gave authority to the Centers for Medicare & Medicaid (CMS) to provide incentives for providers who become meaningful users of certified electronic health records. For an overview of the Medicare and Medicaid Programs; Electronic Health Record Incentive Program Final Rule please go to **http://www.ofr.gov/inspection.aspx#spec_C**

The Final Rule for Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology has also been posted and can be found at **http://www.ofr.gov/inspection.aspx#spec_H**

The proposed rulemaking was released at the end of 2009, and since that time CMS, ONC, and the HIT Policy Committee, considered thousands of public comments and worked together to define provisions that will provide the incentive payments to eligible providers and hospitals who achieve meaningful use. This provision, defining meaningful use, has been updated in the final rule to reflect a more flexible, consistent, and simpler message.

Some interesting changes to note in the final rule:

- More **consistent** message between CMS programs
- **Easier** calculations of measures
- Greater **flexibility** in achieving objectives

With this announcement, we are excited for the opportunity to work alongside you to provide resources and assistance as you take the steps toward adopting, implementing, upgrading or go directly to meaningfully using a certified EHR. We will work provide training and support services to help your adoption; information and guidance to smooth the implementation process; and technical assistance as needed. Please visit us **www.widerivertec.org**. We look forward to working with you in achieving meaningful use of electronic health records. ☐

MARK YOUR CALENDARS

International Roundtable for Community Paramedicine
August 9-10, 2010 - Vail, CO - cmontera@wecadems.com

3RNet Annual Conference
September 14 - 16, 2010 - Charleston, SC

Nebraska Rural Health Advisory Commission Meeting
September 15, 2010 - 6:30 p.m.
Kearney, NE Holiday Inn

CRHC Billing and Coding Workshop
September 16, 2010 - 8:00 a.m. - 4:30 p.m.
Kearney, NE - Holiday Inn

2010 Annual Nebraska Rural Health Conference
September 16-17, 2010 - Kearney, NE - Holiday Inn
www.RuralHealthWeb.org

NRHA Rural Health Clinic Conference
Sept. 28 - 29, 2010 - Kansas City, MO

NRHA Critical Access Hospital Conference
Sept. 29 - Oct. 1, 2010 - Kansas City, MO

Nebraska Rural Health Advisory Commission Meeting
November 12, 2010 - 1:30 p.m. - Lincoln, NE

NRHA Rural Multiracial and Multicultural Health Conference
Dec. 1 - 3, 2010 - Tucson, AZ

The Nebraska Registry Partnership maps the way to improved quality of care

by David Howe

Whether on an athletic playing field, in the boardroom, or almost anywhere else, measuring performance and learning how to improve it are key.

Healthcare, of course, is no exception.

One example is the Nebraska Registry Partnership. A group Nebraska healthcare organizations formed it 4 years ago, with help from a $130,000/year Centers for Disease Control grant. The Registry focuses on how rural health clinics can best meet the care needs of cardiovascular disease and diabetes patients. The ultimate goal is to use the lessons learned to create a model for adoption by other clinics.

This Registry focuses on prevention and management of those two chronic diseases by doing the following:

- Tracking and documenting how well participating clinics' practices and procedures are meeting their diabetes and cardiovascular disease patients' healthcare needs. That includes monitoring trends within a patient population for such factors as blood pressure, cholesterol levels, and hemoglobin A1c levels.
- Teaching clinics to use this data to drive changes in care practices.
- Helping clinics and their patients touch all of the necessary bases with treatments, medications, lab tests, exams, dietary guidelines, and scheduled follow-up visits. Emphasis is on helping clinics, for example, to identify which and when tests and exams should be ordered to achieve improved quality of care. It's also to help patients carry through with providers' instructions.

So, how's it working out? Evaluations by Registry Evaluator Kim Galt and statistics provided by Registry Coordinator Andrea Riley in the Nebraska Department of Health and Human Services (DHHS) are summarized in the accompanying sidebar article.

The Registry tracks 23 different items for diabetes patients and 18 for cardiovascular patients, according to Registry Coordinator Riley. That's accomplished through an Internet-based chronic disease registry software program called DocSite. It functions as a "tickler file," reminding clinic staff what they should be doing and when, using current best practices in diabetes and cardiovascular health management.

Clinics can contact patients to return to the clinic to get scheduled tests and exams, such as cholesterol tests and foot and eye exams for disease prevention and management.

Blood pressure is recorded at each visit for every patient. Clinics and patients can use this information to compare how their blood pressure has changed over the past several years, Riley explains. If blood pressure or some other measure is high, DocSite will alert providers that the patient needs to come back to the clinic to get re-checked.

Some measures, such as hemoglobin A1c and cholesterol, are charted in a bar graph and given to patients as a visual reminder of how their

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Veterans hotline and online chat

With Help Comes Hope

Are you in crisis? Please call 1-800-273-TALK

Are you feeling desperate, alone or hopeless? Call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255), a free, 24-hour hotline available to anyone in suicidal crisis or emotional distress. Your call will be routed to the nearest crisis center to you.

- Call for yourself or someone you care about
- Free and confidential
- A network of more than 140 crisis centers nationwide
- Available 24/7

Registry *cont'd from p. 6*

levels have tracked over time, according to Riley. These patient handouts also include a printout of how patients' laboratory values compare with goals, and direct patients on when their next tests are due.

Through DocSite, data for a clinic's patients are aggregated, which lets each clinic in the Registry track trends not only for its own patient population but also compare trends in the clinic's population with those for patient populations of all participating clinics. Clinics can, for example, monitor what percentage of their patients are keeping their follow-up appointments, keeping cholesterol levels under control, staying on track with medications, and following prescribed dietary guidelines.

Through the Registry, clinics can share data with each other and identify procedures and practices that lead to improved quality of care for cardiovascular and diabetes patients, according to Registry Evaluator Galt.

Some providers may see the Registry as filling essentially the same role that electronic health records (EHRs) do. But, the two have different roles to play, according to Galt. EHRs focus on patients individually. The Registry, by contrast, is an aggregation of individual outcomes among a group of patients to create an overall picture for the group, she explained.

With most EHRs, said Riley at DHHS, it would be impossible to do things such as get an average blood pressure for all the patients who have diabetes or history of heart attack.

The Registry is a "relatively inexpensive way" for clinics to provide evidence of quality of care, Galt said. Documentation that a registry can provide will become increasingly important with the growing emphasis on tying provider reimbursement to quality of care, as seen with the most recent publication of the "meaningful use" guidelines from the Centers for Medicare and Medicaid Services (CMS), said Galt.

"It's taken a couple of years (for the Nebraska Registry Partnership project) to get up to speed," she added. It began with about 15 rural health clinics. In the past year, Registry participation has declined to about a half dozen clinics with a total of just over 1,000 cardiovascular and diabetes patients, according to Riley at DHHS.

Some of the reasons for that are the challenges that Galt describes in the accompanying sidebar article. The upside, however, is that those remaining clinics are "intensively involved" in the Registry, Galt said.

Registry staff in the Nebraska DHHS have worked on improving reports for accuracy and completeness, going from quarterly reports to monthly reports. More frequent reporting has led to better communication between DHHS and the clinics, according to Riley. "Everybody is more engaged—the patients, nurses, doctors, and receptionists."

The Nebraska Registry Partnership "is really leading the way because the Registry is a multiple-disease approach," Galt said. In time, it could be expanded to include other chronic diseases, asthma being one example, she said.

The aforementioned CDC grant expires this year, leaving some uncertainty about funding for continuation of the Nebraska Registry Partnership, which includes the following healthcare organizations: CIMRO of Nebraska, Nebraska DHHS Cardiovascular

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Suicide prevention resources:

Nebraska State Suicide Prevention Coalition: www.suicideprevention.nebraska.edu

Nebraska Rural Response Hotline: (800) 464-0258.

Registry *cont'd from p. 7*

Health Program, Nebraska DHHS Diabetes Prevention and Control Program, Nebraska DHHS Office of Rural Health, and the Nebraska Rural Health Association.

The CDC grant covered each clinic's DocSite licensing fee the first year, two-thirds of the fee the second year, and one-third in the third year, which is this year. A registry wouldn't necessarily have to use DocSite, but registry recordkeeping without it would be onerous, according to Galt. What the future holds for continuing with DocSite or some other software program is being weighed by the Registry Partnership, according to Galt.

Registry clinics are now being trained in Quality Improvement (QI) through training DVDs and individual work with a QI expert. Each clinic is asked to focus on areas that need improvement, such as high blood pressure, and ways to improve outcomes, according to Riley. "We expect to see further improvement after this intensive intervention is completed in the next several months."

Riley said the Registry would like to add more clinics. Separate funding for the Registry has come from the Cardiovascular Health Program, the Diabetes Prevention and Control Program, and the Office of Rural Health in the Nebraska DHHS, she noted. Those may be sources of further support for the Registry, according to Riley. "Everybody feels this is a worthwhile project." For more information, contact Kari Majors at **kari.majors@nebraska.gov** ☐

Nebraska Registry Partnership: how it's faring so far

It's review time for the Nebraska Registry Partnership, a program begun 3 years ago to help a group of rural health clinics (RHCs) zero in on prevention and management of cardiovascular disease and diabetes for their patients.

"There really are some challenges that people have faced (in implementing the Registry)," Registry Evaluator Kim Galt has noted in her evaluations. But, she observed, the Registry is providing some useful patient population-based information for disease management, as noted a bit later in this article.

Following are some of Galt's general observations:

- Timely patient data entry for the Registry and assurance of patients' adherence to prescribed appointments, treatments, tests, exams, and medications add significantly to staff workload.
- How to integrate Registry responsibilities into daily workflow needs more thought.
- No efficient, affordable system is yet available to overcome data entry duplication for electronic health records (EHRs) and DocSite, each fulfilling a different need. "That's not an uncommon problem in healthcare," Galt said.

The Nebraska Registry Partnership team decided a survey of the state's 125 RHCs' use of a registry of any kind would be a helpful guide to what direction the Nebraska Registry Partnership should take in the future.

Of the 90 RHCs that responded to the survey, only 30 reported use of a registry of any kind, according to Galt. Those include the six rural health clinics continuing to participate intensively in the Nebraska Registry Partnership. Twenty-five of the 30 clinics are provider-based. The other five are independent rural clinics.

"Users indicate that a registry was somewhat better or better than what they did before they had a registry," Galt reported. Two-thirds of the 30 clinics using a registry reported that it met their needs, according to her report.

Referring to the RHCs in the Nebraska Registry Partnership, she reported: "Much

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learning occurred and the six core clinics remaining have become 'registry smart,' improved their chronic disease management indicators, and gained expertise in the incorporation of chronic disease management systems for care designed to improve quality."

In concluding remarks of her evaluation, Galt noted: "Expansion of the Registry model that emphasizes chronic disease management is warranted. Continued education about how to incorporate quality improvement and chronic disease management is needed. The Nebraska Registry Partnership has successfully provided this in its sustained success in six RHCs in the state, " Galt said. "The leadership of Jamie Hahn as the Nebraska Registry Partnership director has resulted in a high quality project that has provided the state with needed learning."

That's borne out by the population-based information data provided by Registry Coordinator Andrea Riley in the Nebraska Department of Health and Human Services (DHHS).

Patient data (reported by medical record numbers rather than patients' names) is submitted by participating clinics to DHHS analysts. Among findings revealed by those analyses, according to Riley:

- In the last quarter of 2009, 29% of diabetes and cardiovascular disease patients had not been to a clinic in more than 12 months. By the end of the first quarter this year, the percent of patients who had gone more than 12 months without visiting a clinic was down to 13%. "One thing I think we've done a good job of is getting patients back into the clinics," Riley said. "We call it 'recall.' Clinics are doing a lot better job of recall," she added. "Patients, themselves, are more aware of what they should be doing."
- The percentage of diabetes patients who had gotten a dilated eye exam in the past 12 months, with the eye doctor's verification sent to the clinic, increased from 33% in the second quarter of 2009 to 44% in the first quarter of 2010. "This is a tough one for people to complete, because most of our patients have to get someone to drive them to another town to get this done," said Riley.
- The percentage of diabetes patients who had gotten a foot exam in the past 12 months increased from 62% in the second quarter of 2009 to 73% in the first quarter of 2010.
- The percentage of clients who have been asked whether they are taking aspirin daily increased from 35% in the fourth quarter of 2008 to 44% in the first quarter of 2010.
- The percentage of patients who had been asked whether they are using tobacco has increased from 55% in the fourth quarter of 2008 to 81% in the first quarter of 2010.
- The percentage of patients who had been asked whether they are exercising regularly had increased from just 20% in the fourth quarter of 2008 to 60% in the first quarter of 2010.

Improvement is less dramatic in some categories, but still worthwile, said Riley. For instance, according to numbers she reported, those who had their overall cholesterol under control increased slightly between the last quarter of 2008 and the first quarter of 2010—from 71% to 76%. And, the percentage of patients who had their overall LDL cholesterol under control increased slightly, from 53% in the last quarter of 2008 to 58% in the first quarter of 2010.

However, as Galt pointed out, "the changes are in the direction of improvement in quality of care. And, in chronic disease management, these changes are meaningful indicators of an effective program." ☐

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If you have any questions, please e-mail Ann.Larimer@nebraska.gov.

The "future" of rural health?

By John Roberts, Nebraska Rural Health Association

Today, there are nearly as many mobile phones (600 million) in existence that can browse the Internet and access email as there are personal computers (800 million) so it makes sense to think about greater use of mobile health.

One of the virtues of the Internet, electronic medical records, and cell phones is that it puts the patient in charge of certain activities. Using remote monitoring devices, people can measure their own weight, blood pressure, pulse, and sugar levels, and send test results electronically to health care providers. They get personalized feedback via email and reminders when they gain weight, have an uptick on their cholesterol levels, don't take their medicine, or have high blood pressure. Social networking sites provide discussion forums and the benefit of collective experience from other people suffering similar problems. Patients take responsibility for their routine health care and rely on physicians for more serious medical conditions.

This system is not a futuristic vision, but is within our grasp. It would cut costs by reducing professional responsibility for routine tasks and record-keeping, while also making it possible for patients to receive higher quality care and be more satisfied with the end-result. The technologies for this kind of system transformation currently are available through cell phones, remote monitoring devices, video conferencing, and the Internet. There are a number of new remote monitors for various health care conditions that put patients in charge of their own test-taking and keep them out of doctor's offices.

For example, there are home pulse-taking and blood pressure devices that measure vital signs. AT&T has a new "device certification lab" that tracks health along high-speed broadband networks. Results are electronically sent to a family physician, specialist, or electronic medical record, depending on the wishes of the patient. Zeo is marketing a monitor that measures brainwaves and rates the quality of sleep. Bodybugg has an armband calorie-counter that charts the amount of energy burned through physical movements. The Triage Wireless company has a "wearable" monitor that records vital signs and transmits them to physicians. It records blood pressure on a continuous basis, thereby providing regular information for health care providers. The Corventis Corporation has a small sensor it calls PiiX that measures fluid status and respiration for runners. This helps people monitor their physical status during exercise. Intel has a "magic carpet" device that monitors physical movements. Geared for senior citizens at risk of a fall, it tracks people as they walk on a mat to determine who is vulnerable to falling down.

In the area of diabetes, it is crucial that patients monitor their blood glucose levels and gear their insulin intake to proper levels. In the "old days", patients had to visit a doctor's lab or medical office, take a test, and wait for results to be obtained. That process was expensive, time-consuming, and inconvenient for all-involved. Having to get regular tests for this and other conditions drives up the costs of medicine. However, it is possible to use remote monitoring devices at home that record glucose levels instantaneously and electronically send them to the appropriate health care provider. Patients are using with FDA-approved "Gluco Phones" that monitor and transmit glucose information to caregivers while also reminding patients when they need to undertake glucose tests. It is estimated that over 11 million Americans use home monitors for their glucose. Health authorities believe there are over 24 million diabetics in the United States, and the disease is the seventh leading cause of death.

One of the biggest problems in medical treatment are patients forgetting to take their prescription drugs. It is estimated that only 50 percent of patients take their medication as prescribed. Either they forget to take the drug or they do not take it at the time or dosage set by their physician. This means that we lose half of the benefit of prescription drugs through human

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Future *cont'd from p. 10*

error. This costs the systems billions in poor health outcomes. Digital technology has the potential to help with this and other communications problems. Patients no longer need to visit doctors' offices to be reminded to take their medicine. They can get personal reminders via email, automated phone calls, or text messages. In the United States, Dynamed Solutions provides "HealtheTrax" software that reminds patients to take medications, set up appointments, and track compliance with medical instructions. This and other types of "virtual health assistants" are particularly helpful with those suffering from chronic illnesses. These individuals need to keep close track of their medical condition and stay in touch with their caregivers. The software is integrated with electronic medical records and can store information in patient's personal records.

Cell phones and other mobile devices have gotten smarter and faster. Smartphones such as Apple's iPhone, Research in Motion's Blackberry, Nokia's E71, and Palm Pre offer advanced features such as mobile email, web browsing, and wireless communications. The sophistication of these devices has spawned a variety of new medical applications that help doctors and patients stay in touch and monitor health care needs. For example, Sprint has a mobile application that allows physicians to get test results on their mobile device. They can look at blood pressure records over time, see an electro-cardiogram, or monitor a fetal heart rate. AirStrip Technologies markets an application that makes it possible for obstetricians remotely to monitor the heart rates of fetuses and expecting mothers. This allows them to detect conditions that are placing either at risk. These applications make doctors more efficient because they don't have to be in the physical presence of a patient to judge his or her condition. Digital technology allows people to overcome the limitations of geography in health care and access information at a distance. This makes it possible for veterans to get a second opinion without visiting another physician by sending that person relevant medical tests. If a personal conference is required, doctors can use video conferencing to speak to patients located in another city or state.

Social networking sites offer great potential to improve care by sharing information among chronic condition sufferers. For example, a network developed by the company Patients Like Me has 23,000 patients who have signed up to share information regarding five different illnesses: mood disorders, Parkinson's, multiple sclerosis, HIV/AIDS, and Lou Gehrig's disease. These individuals describe their symptoms, discuss various therapies, and talk about what works and doesn't work very effectively. Not only does the site serve as a vital support group for these serious illnesses, it promotes better understanding through the detailed case histories based on personal experiences.

A similar idea draws on crowd-sourcing for feedback regarding medical care and treatment side-effects. It often takes years for patients, physicians, and medical researchers to get definitive results regarding the assessment of drugs and medical therapies. Clinical trials are expensive and time-consuming, and involve randomized assignment to various groups. Results sometimes are unclear and it is hard to recruit sufficient subjects to participate in the evaluations. While it is important to maintain rigorous approaches to medical research, it is helpful to take advantage of new techniques for getting feedback. Crowd-sourcing is a concept that takes advantage of the collective experience of large groups of people. It allows a variety of individuals to comment on and post experiences with specific treatments. This helps others compare data and see information on what works or doesn't work.

In general, Americans say they would like to employ digital technologies in their medical care. For example, 77 percent in a national survey said they would like to get reminders via email from their doctors when they are due for a visit, 75 percent want the ability to schedule a doctor's visit via the Internet, 74 percent would like to use email to communicate directly with their doctor, 67 percent would like to receive the results of diagnostic tests via email, 64 percent want access to an electronic medical record to capture information, and 57 percent would like to use a home monitoring device that allows them

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to email blood pressure readings to their doctor.

These types of technology can lower costs and improve quality. The Geisinger Medical Center tested a "medical home" initiative among Medicare patients and found an 8 percent drop in hospital admissions and a 4 percent reduction in overall health costs over the first year. In this concept, patients are assigned a family physician who acts like a "personal health coach". This coach oversees a group of providers who monitor people's medical condition and use emails and text messages to encourage people to lose weight, stick to healthy diets, get exercise, and seek relevant care when their status deteriorates.

Too many parts of our system today do not cover mHealth, digital communications, or wellness programs. This is problematic in rural areas because mobile health can improve quality, access and affordability. For example, we need better access to video conferencing which allows patients who live long distances to get consultations with specialists. We need policy changes that encourage high quality medical care and make it possible for health providers to be reimbursed for the health they provide.

There is no magic bullet for our health care system in rural America, but there have been technological advances that make it possible to improve quality, access, and affordability in rural America. (The products cited are included as examples of technology available, and not endorsed by NeRHA or the Nebraska Office of Rural Health.)☐

Tax relief for Nebraska Loan Repayment Program participants

Public Law 111-148, of the Patient Protection and Affordable Care Act, which became law on March 23, 2010, contained the following amendment. Section 10908 of this law states, "Payments under…certain state loan repayment programs – in the case of an individual, gross income shall not include any amount received… under any other State loan repayment or loan forgiveness program that is intended to provide for the increase availability of health care services in underserved or health professional shortage areas (as determined by such State)." The effective date of this amendment applies to payments received by an individual in taxable years beginning after December 31, 2008.

To Nebraska Loan Repayment Program recipients who received loan repayment payments from the State of Nebraska in 2009, you should have received revised Form 1099 from the Nebraska Department of Administrative Services. State loan repayment recipients will have to contact their tax preparers about filing amended returns for both state and federal income tax for 2009.

The Nebraska Rural Health Advisory Commission has been working with Nebraska's congressional representatives since 2004 on tax relief for state-funded loan repayment programs. It was in 2004, that federal loan repayment programs under the National Health Service Corps (NHSC) were tax exempt but that exemption did not apply to state-funded programs that did not meet the NHSC guidelines.

• Update of State-Designated Shortage Areas

The Rural Health Advisory Commission (RHAC) approved new state-designated shortage areas that became effective July 1, 2010. The RHAC does a statewide review of shortage areas every 3 years. There was a 30-day public comment period for interested parties to exam the proposed shortage areas. The new state-designated shortage areas are posted on the Nebraska Office of Rural Health website at www.dhhs.ne.gov/orh. Changes to these shortage areas can be addressed by contacting the Marlene Janssen at (402) 471-2337 or marlene.janssen@nebraska.gov.

State-designated shortage areas are used by the Rural Health Advisory Commission for the rural incentive programs, Nebraska Student Loan Program and Nebraska Loan Repayment Program. Recipients currently serving practice obligations in state-designated shortage areas will not be affected by the changes even if their area is no longer a shortage area. ☐

CIMRO of Nebraska awarded Health Information Technology Regional Extension Center Cooperative Agreement

by Jennifer Rathman

CIMRO of Nebraska has created Wide River Technology Extension Center (Wide River TEC) as Nebraska's Regional Extension Center for Health Information Technology (HIT). Regional Extension Centers were established as part of the Health Information Technology for Economic and Clinical Health (HITECH) Act. $6.6 million was awarded to CIMRO of Nebraska, the Medicare Quality Improvement Organization for the state of Nebraska, as a four-year cooperative agreement grant from The Office of the National Coordinator for Health Information Technology (ONCHIT) to establish Wide River TEC to assist Nebraska healthcare providers with implementing and using Electronic Health Records (EHRs).

In April, Wide River TEC announced the appointment of two leadership staff. Dr. Bob Rauner has been selected as the Principal Clinical Coordinator and Todd Searls, most recently with National Jewish Health (NJH) in Denver, Colorado, has been named the Director.

Dr. Rauner, originally from Sidney, Nebraska, obtained a medical degree from the University of Nebraska Medical Center and completed a residency in family medicine at the Lincoln Family Medicine Program. His prior clinical practice includes five years as a rural family physician in Sidney and the last seven years as a faculty physician at the Lincoln Family Medicine Program. He recently completed a term as the president of the Nebraska Academy of Family Physicians. He will be finishing his master's degree in public health at the Johns Hopkins Bloomberg School of Public Health in May. Dr. Rauner stated, "I look forward to beginning this important work. Wide River TEC has tremendous potential to improve the healthcare for Nebraskans, working in collaboration with our numerous partners and supporters."

Searls joins Wide River TEC after having spent the past several years as a Clinical Systems Supervisor at National Jewish Health. In this capacity, he served as the technical lead and coordinator for NJH's Electronic Medical Record (EMR) implementation, heading a team of analysts who maintained the EMR build and hardware, while at the same time facilitating the adoption of the EMR for both the Divisions of Adult and Pediatric Medicine, totaling almost 200 physicians across 20+ specialties. Since 2001, Searls has implemented and advanced a host of healthcare IT initiatives through senior leadership positions in both independent provider-owned practices, as well as large multi-facility healthcare systems. "I am honored and pleased to accept the position of Director at Wide River TEC. With so many new federal regulations facing Nebraska physicians, my first priority will be to assist these providers in navigating the technical and regulatory challenges ahead, so they may continue to focus on what matters most – their patients," stated Searls.

Wide River TEC will offer technical assistance, guidance and information on best practices to support and accelerate healthcare providers' efforts to become meaningful users of EHRs, as well as the ability to exchange health information with other providers and agencies. Wide River TEC services will be available to all healthcare providers in the state, including those who already have an EHR in place.

Priority will be given to Nebraska practitioners providing primary care in individual and small-group practices; Critical Access Hospitals providing primary care; rural health clinics; Federally Qualified Health Centers; and other settings that serve uninsured, underinsured and medically-underserved populations. Individual provider education and training will be conducted through onsite visits and individualized technical assistance. A team approach will be utilized, with highly-trained nursing informatics and technical specialists providing technical assistance.

If you are a Nebraska practitioner interested in learning more about Wide River TEC's services, visit the Wide River TEC Web site to download the commitment form at www.widerivertec.org. For more information, contact Greg Schieke, Senior Vice President at gschieke@widerivertec.org ☐

HHS announces final rules for meaningful use of EHR's

Wide River TEC designated to advise Nebraska healthcare providers on making electronic health records a reality

U.S. Department of Health and Human Services Secretary Kathleen Sebelius announced final rules to help improve Americans' health, increase safety and reduce healthcare costs through expanded use of electronic health records (EHR) July 13, 2010.

Wide River Technology Extension Center (TEC) is one of 60 Regional Extension Centers around the country, designated to offer healthcare providers a local resource for technical assistance, guidance, and information on best practices to support and accelerate healthcare provider efforts to become meaningful users of EHR.

"For years, health policy leaders on both sides of the aisle have urged adoption of electronic health records throughout our healthcare system to improve quality of care and ultimately lower costs," Secretary Sebelius said.

Established under the HITECH Act under the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, eligible healthcare professionals and hospitals can qualify for Medicare and Medicaid incentive payments when they adopt certified EHR technology and use it to achieve specified objectives. One of the two regulations announced July 13 defines the "meaningful use" objectives that providers must meet to qualify for the bonus payments, and the other regulation identifies the technical capabilities required for certified EHR technology.

With "meaningful use" definitions in place, Wide River TEC will be working with primary care providers and their practices to ensure that the EHR system they acquire will support achievement of "meaningful use" objectives. With the announcement, a concentrated five-year national initiative to adopt and use electronic records in healthcare can begin.

"The Meaningful Use incentives and Regional Extension Centers will help physicians improve the quality of care they provide by successfully implementing the most important features of electronic health records," stated Robert Rauner, MD, MPH, FAAFP, CPHIT, Principal Clinical Coordinator, Wide River TEC. "I am very excited about the final rules for meaningful use. It is very apparent to me that the ONC has listened to the thousands of public comments on the initial proposed meaningful use incentives and have addressed most of the problems. The final rules make sense and have a reasonable time frame for implementation. This is the right thing to do for both patients and physicians."

Two companion final rules were announced July 13. One regulation, issued by the Centers for Medicare & Medicaid Services (CMS), defines the minimum requirements that providers must meet through their use of certified EHR technology in order to qualify for the payments. The other rule, issued by the Office of the National Coordinator for Health Information Technology (ONC), identifies the standards and certification criteria for the certification of EHR technology, so eligible professionals and hospitals may be assured that the systems they adopt are capable of performing the required functions.

"Wide River TEC is partnering with Primary Care Providers across the state to ensure successful adoption of Health IT to meet Meaningful Use criteria," said Todd Searls, Director of Wide River TEC. "In understanding the unique challenges facing today's healthcare provider, we fill the role of trusted advisor for providers in Nebraska offering a functional combination of national

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insight and local expertise."

The CMS rule announced July 13 makes final a proposed rule issued on Jan. 13, 2010. The final rule includes modifications that address stakeholder concerns while retaining the intent and structure of the incentive programs. In particular, while the proposed rule called on eligible professionals to meet 25 requirements (23 for hospitals) in their use of EHRs, the final rules divides the requirements into a "core" group of requirements that must be met, plus an additional "menu" of procedures from which providers may choose. This "two track" approach ensures that the most basic elements of meaningful EHR use will be met by all providers qualifying for incentive payments, while at the same time allowing latitude in other areas to reflect providers' needs and their individual path to full EHR use.

"Healthcare is finally making the technology advances that other sectors of our economy began to undertake years ago," said David Blumenthal, MD, MPP, National Coordinator for Health Information Technology. "These changes will be challenging for clinicians and hospitals, but the time has come to act. Adoption and meaningful use of EHRs will help providers deliver better and more effective care, and the benefits for patients and providers alike will grow rapidly over time."

CIMRO of Nebraska, the Medicare Quality Improvement Organization for the state of Nebraska, was awarded a four-year cooperative agreement grant from The Office of the National Coordinator for Health Information Technology (ONCHIT) to establish Wide River TEC to assist Nebraska healthcare providers with implementing and using EHRs. Wide River TEC offers technical assistance, guidance and information on best practices to support and accelerate healthcare providers' efforts to become meaningful users of EHRs, as well as the ability to exchange health information with other providers and agencies.

If you are interested in learning more about Wide River TEC's services, visit the Wide River TEC Web site for additional information at **http://www.widerivertec.org.**

For additional information about the Health Information Technology Regional Extension Centers, see **http://HealthIT.hhs.gov/programs/REC/**. ☐

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ACCESSory Thoughts

COMMUNITY MATTERS

Dennis Berens, Director
Nebraska Office of Rural Health

"Community matters" is more than a nice set of words with a dual meaning. It is a reality and a frame that we must do a better job explaining and advocating for these days. Rural may matter to us, but does it matter to the rest of the state or country?

Does your community matter today? Do we really know the difference between our rural myths and our rural realities, resources and opportunities? Do we really understand our strengths, and can we see where rural can lead?

I believe that for most of us these issues are really matters of the heart. It would be wonderful if we could transform those feelings into strategies and actions that have a sense of urgency stemming from a large amount of knowledge. Logic needs a frame, and we need to create a frame that tells the rural health and health care story with all the values that we hold dear.

We must ensure that community matters for the sake of its members, our citizens, and for the sake of our nation and world.

Communities need their members to be involved if they are to be sustainable. I think they also want their members to participate in public life as a way to improve the health and health care of their fellow citizens. They want action, they want to see growth and improvement.

Underlying all the strategies employed in health and community development models is also the assumption that people have a right to participate in public affairs that affect their lives. What affects us more than our individual health and the health care system we need at times to help us.

I truly believe that communities want to be better, healthier, more economically viable and safer for their neighbors, friends, family and themselves.

Please take some time to help transform your community by explaining why communities matter and framing the health and health care issues in a resource positive frame.

Communities matter because every citizen matters, and we all have matters that need to be addressed. ☐